Centra Wellness
NETWORK

September 13, 2016

Representatives
Michigan Full House Appropriations Committee
Michigan House of Representatives
P.O. Box 30014
124 N. Capital Avenue
Lansing, Michigan 48909-30014

Dear House Appropriation Members;

House Bill 5118 State General Fund Allocation Funding Methodology Bill amending the "Mental Health Code" is due to come before your committee in the very near future. After working in Community Mental Health for 27 years I have never been able to understand the current allocation process wherein a citizen in Manistee and Benzie Counties receives only 1/5 the amount of State Mental Health General Funds as compared to some other Community Mental Health Board and ½ the State average per person.

The only explanation I have ever received from anyone in authority is that it is based on historical funding (PRE 1980) and politics. To me this is not a good way to allocate mental health resources. The formula should be clearly understood to all sub-political units of the State and especially the citizens. The current funding arrangement in mental health makes the divide between well-funded school districts small in comparison.

So therefore, Centra Wellness Network a/k/a Manistee-Benzie Community Mental Health Organization fully supports House Bill 5118 for passage and amendment of P.A. 258 of 1974, as amended.

If you have any questions please feel free to call me at 1-231-309-1724.

Sincerely,

Joseph "Chip" Johnston
Executive Director
Centra Wellness Network

Cc: Rep. Ray Franz
Senator Darwin Booher
CWN Board of Directors

KALAMAZOO COMMUNITY
Mental Health
& Substance Abuse
Services

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www.kazoocmh.org

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Chief Executive Officer

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Testimony
Michigan House Appropriations Standing Committee Meeting
September 14, 2016

September 12, 2016

Representative Aaron Miller
Michigan House of Representatives
59th District
N-993 House Office Building
P.O. Box 30014
Lansing, MI 48909

Dear Representative Miller:

It has been nearly 19 years after the Citizens Research Council of Michigan published its January 1997 Report No. 318 regarding the Funding of Community Mental Health in Michigan. The report highlighted the following:

> The allocation of dollars from the state to Community Mental Health boards evolved over twenty years as a result of historical factors having to do with the timing of the adoption of full management contracts with the state, the character of budget submissions by various CMH boards, and, to an extent, political considerations. A process is needed whereby CMH dollars are distributed in a more equitable manner and which facilitates a move to managed care.[1]

The report recommended that:

> A reformulated distribution of dollars should incorporate elements that reflect state objectives for fund distribution. These objectives include:
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> - Adequate funding of effective services
> - Maintenance of community responsibility and authority for implementing state and local priorities
> - Equitable distribution of CMH dollars
> - Promotion of the development of innovative programs

In addition to supporting these objectives, a new funding formula must take into account other developments that are either underway or are reasonably likely to occur. Principal

[1] Citizens Research Council of Michigan, Funding Community Mental Health in Michigan, Report No. 318, January 1997.

among these are the adoption of managed care systems at both the state and federal levels and the possibility of a move to block grants by the federal government.[2]

The managed care carve-out, which was considered for elimination in Section 298 of the Governor's Executive Budget Recommendations for Fiscal Year 2017, was implemented in 1998 – one year following the Citizens Research Council Report. Unfortunately, very little has been accomplished to satisfactorily equalize state general funds for the 46 county-sponsored Community Mental Health Services Programs (CMHSPs) in Michigan. In fact, over these years more has been done to actually reduce general fund appropriations to CMHSPs than formulate equity distribution statewide.

The 2004 Michigan Mental Health Commission Final Report found that, "by moving to community based services the CMH system has saved the State hundreds of millions of dollars and improved the quality of services over the past twenty years, however much of the savings created by this movement were not retained in the CMH system to support consumers in the community."[3]

There are several reasons for this. First, with the Medicaid managed care carve-out for specialty mental health and substance use services beginning in 1998, CMHSP general funds were split into the state required match needed for the contribution to Medicaid funded program, and the residual community general funds benefit.[4] Briefly, under managed care the following changes to state general fund appropriations occurred:

- ✓ The Fiscal Year 1999 residual general funds were $414 million, which represented about 41% of the total CMHSP general fund authorizations;
- ✓ Also during Fiscal Year 1999, the legislature approved a direct care wage increase, which was mostly funded through the Medicaid specialty services program;
- ✓ There were no general fund increases in general funds from Fiscal Year 1999 through Fiscal Year 2002.
- ✓ In Fiscal Year 2003, there was a 2.5% across the board reduction in general funds to CMHSPs;
- ✓ In Fiscal Year 2004, $40 million of CMHSP general funds were removed to finance a large portion of the Adults Benefits Waiver program. Note: after the end of this program, these general fund dollars were not restored to the CMHSP system.
- ✓ During Fiscal Year 2006, the legislature approved another Direct Care Wage increase, but still no increase to general fund appropriations.
- ✓ During this period forensic case in state psychiatric hospitals added to the burden on CMHSP general funds;
- ✓ During the last quarter of Fiscal Year 2009 CMHSP general funds were reduced by $10 million and another $40 million in Fiscal Year 2010.
- ✓ In Fiscal Year 2011 a $1.6 million general fund reduction in services occurred along with a reduction of $3.4 million in CMHSP administration.

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[2] Ibid

[3] Michigan Mental Health Commission, Part I: Final Report, October 15, 2004.

[4] Judith Taylor, Ph.D., Michigan CMH System: Financing the General Fund Story Community, Inclusion and the Public Mental Health Safety Net, Michigan Association of Community Mental Health Boards Spring Conference, 2015.

- ✓ In Fiscal Year 2012 another $5.1 million of CMHSP general funds were reduced for services along with a reduction of $3.4 million in CMHSP administration.
- ✓ There were no CMHSP general fund reductions during Fiscal Year 2013.
- ✓ In Fiscal Year 2014 with the launching of Healthy Michigan, there was a 55% reduction in CMHSP general funds for the last six months of the year.
- ✓ In Fiscal Year 2015 a further impact of Healthy Michigan on CMHSPs occurred with a total loss of 66% (or $187 million) of CMHSP general funds. (It should be noted here that general funds supporting all CMHSP services in Fiscal Year 2015 to the present is roughly the same as state general funds to CMHSP in the 1990s.[5]

Despite these enormous losses in state general funds for CMHSPs since 1997 (nineteen years), arguments are made that more Medicaid funding is now available through the Medicaid Managed Specialty Services Program and Healthy Michigan, which replaces the need for general funds. This argument does not take into account the fact that many people that CMHSPs are statutorily responsible for serving are still ineligible for Medicaid benefits, namely people on Medicaid spend-down status. General funds are needed for this population. Also, Medicaid does not cover room and board for crisis residential services, community living services (i.e., specialized residential group homes), and unsubsidized private rental housing supports. If an individual does not immediately have private resources or Supplemental Security Income (SSI) to support room and board in these settings, many of these individuals would become homeless or would be at risk for homelessness following discharge from institutional settings. General funds are clearly needed to assure safe and affordable housing for these individuals.

General funds are also needed for children and adolescents that require out-of-home care in Child Caring Institutions (CCIs) in Michigan because of the federally mandated seclusion and restraint rules that prohibit the use of Medicaid funds for these types of organizations that do not comply with these rules. This alone is estimated to require $1 million in general funds statewide. CMHSPs have to use general funds to support psychiatric hospitalization use for people admitted in private freestanding hospitals in Michigan that are designated as Institutions for Mental Disease (IMDs). Medicaid currently prohibits funding for these organizations. The use of Medicaid funds is also prohibited for jail services delivered by CMHSPs.

Finally, I want to point out that Section 8 of Article 8 in our state constitution provides the following:

> Institutions, programs and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally or otherwise seriously handicapped shall always be fostered and supported.[6]

The Citizens Research Council Report of 1997 rightfully pointed out that:

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[5] Judith Taylor, Ph.D., Michigan CMH System: Financing the General Fund Story Community, Inclusion and the Public Mental Health Safety Net, Michigan Association of Community Mental Health Boards Spring Conference, 2015.

[6] Citizens Research Council of Michigan, Funding Community Mental Health in Michigan, Report No. 318, January 1997.

> The move toward community-based care was anticipated in the 1963 Constitution because the requirements of the 1850 and 1908 Constitutions regarded institutions as the exclusive means of treating the mentally ill. The delegates of the 1961 Constitutional Convention, having concluded that such a restrictive focus was no longer appropriate, added language that declares that not only "institutions" but also "programs and services" are to be "fostered and supported.[7]

Unfortunately, Michigan and most other states depend heavily on federal support to finance Behavioral Health and Intellectual-Developmental Disability services. That means that mental health programs are increasingly becoming federalized through Medicaid and states are losing control over how programs are being developed and managed. We are now beginning to see how behavioral health programs in most states are losing the battle to preserve its home and community-based services to the larger Medicaid and Medicare managed health plan model of medical service delivery and financing. This is because many states are no longer investing state resources to foster and support mental health services. It is my hope that we can turn this trend around in Michigan by not only restoring state general funds to CMHSPs, but equitably redistribute existing and new general funds to carry out the very important mission and statutory responsibilities of CMHSPs. I appreciate and applaud you in your efforts to raise these issues to the legislature and general public in this meeting. Unfortunately, I was not possible for me to attend this meeting today, but certainly will be available to answer questions or provide other support for these very important issues.

Sincerely,

Jeffrey W. Patton
Chief Executive Officer

[7] Ibid

Judith Taylor, Ph.D.
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517-655-2729

September 14, 2016

REGARDING: HB5118 and the allocation of Community Mental Health General Funds to the CMHSPs

Dear Representative Miller and colleagues

Since I am unable to attend the hearing on HB5118 I am providing written testimony. First let me introduce myself. I have been actively involved with the Michigan public mental health system for almost 40 years, as both an advocate and as a consultant, and more specifically as the chief historian tracking the evolution of the system and its financing. I have seen the system grow and change to better meet the needs of some of Michigan's most vulnerable residents. One of the areas I have tracked since 1980 is the financing of the CMH system, with particular reference to the allocation and use of General Funds. The allocation and redistribution efforts I have personally had a major role for the past 20 years. I am writing this as a concerned advocate and not on behalf of any organization, but on behalf of the over 100,000 consumers and their families who used to benefit from access to GF financed services and supports through their local community mental health program.

While I have developed many materials, analyzed the funding allocations, and done many presentations on the history of CMH financing, I will provide just a brief synopsis. Yes, the funding allocation to the CMHSPs is, and always has been, inequitable. There are many historical reasons for this with some of the key ones being a) the use of state services and the impact of becoming full management where some CMHSPs saw their budgets increase four-fold due to their heavy reliance on state run services, to some CMHSPs who saw increases of less than 50%, b) where the then DMH developed community alternatives to state facilities, and c) how well a CMHSP went after Medicaid funding to help create a stronger community system.

There have been many previous conversations and initiatives over the past 30 years about the CMH GF allocations. In 1996 the state, in conjunction with CMH and the Citizens Research Council, developed a funding model that used three factors. This was applied in FY97 to address a required $15m reduction. The model was modified going into Medicaid managed care in FY99, and was applied several times over the next 12 years. These applications resulted in $25m being re-distributed and considerable reduction in the variance: from a range of 25% to 185% of state average, to 45% to 125%, ie from 7-fold to 3-fold. It should be noted that over the same time period the GF base eroded by $95m.

A key statement of principle that has occurred in all CMH GF equity discussions has been a preference to use new funds to address the low-end CMHSPs rather than having to take away from others. And a KEY FACT is that under the previous funding factors model (applied to the $97m base) it would take only $9.5m to bring the 33 CMHSPs below state average, up to the state average.

Faced with a significant reduction in 2014 (from $284m to an initial $80m, revised to $97m), the state chose to make the reduction be an across-the-board reduction of 65%, equally applied to the 46 CMHSPs, disregarding a well-established pattern of continuing inequity and low end CMHSPs.

Then, when the legislature approved a $20m increase in the CMH GF appropriation (thankyou), the principle noted above, namely use this $20m to target the low-end CMHSPs, was disregarded and the state also applied it across-the-board.

These CMH GF reductions have created huge holes in the public mental health system safety net, and have continued the inequity based on where they live for persons in need of accessing these essential mental health services.

This brings us to early FY15. The state agreed to establish a GF allocation workgroup to help identify and develop new funding factors. Side note, I have participated in at least 6 such efforts over the past 20 years; they can be difficult conversations and often pit winners vs losers. This DHHS run group met monthly and had originally hoped to have something to be used for FY16 allocations. Whilst there were some concerns from "losers" it was not nearly as vocal as had been in previous efforts – in part as the CMHSPs recognized that the across-the-board reduction was very wrong. By December 2015 the group had crafted a model that was well-supported.

Since January, there have been no more meetings and the status of the GF allocation for FY17 (and beyond) appears to have fallen into a black hole. In the meantime, over half of CMHSPs have been overspending their GF allocations (over $16m in Fy15, by 26 CMHSPs), while still making very tough decisions on who not to serve, and at the same time a few CMHSPs have been sending GF back to the state.

There are TWO key constructs that I ask you to consider:

1. **We must implement a better methodology for allocating the CMH GF, and we must do that soon, and**
2. **We must find a way to improve the 236 GF transfer process whereby unspent GF gets transferred to other CMHSPs**

With respect to the model, as was noted above, there was considerable support for the elements that were on the table as of December 2015. These included:

Category One: Recognition that there is a base administrative cost for all CMHSPs necessary to support the minimum infrastructure as a CMHSP and to undertake required activities such as jail diversion. $175,000 per CMHSP; $8.1m)

Category Two: Recognition that there are some priority spending areas that are geographically diverse. While there was discussion about many such topics, there were two that were deemed necessary to include in the model

- The use of GF to help persons meet their monthly spend-down (for CMHSP consumers this averages $600 and yet their income in general is still very low ie $1,100 to $1,600, and thus represents a 35% to 55% per month cost) so that they then can access other necessary services/supports to meet their needs

- The use of GF to cover the costs of persons in Healthy Michigan and now also in Medicaid, who are hospitalized for more than 15 days in free standing community psychiatric hospitals (also known as community hospital IMDs). Over 60% of psychiatric beds in south-east Michigan are in such facilities. Note the scope of this has recently changed from what we knew back in December with the implementation of federal changes in managed care. While we gained for HMP coverage we lost for the basic Medicaid coverage.

Category Three (with approximately $85m): Allocation based on a per capita model using counts of low income persons who are un-insured or under-insured. This would use census based data on persons who are low income, ie below 200% of federal poverty level, and deduct counts of persons insured by Medicaid, including Healthy Michigan.

There is elegance to this model. The factors certainly represent needs with respect to the non-. And the data needed to determine the factors are easily obtained. Thus it is expected that the model be based on calculations for the start of each year, based on recent data.

Finally, the group had recommended to the state that the model be rolled out over a 3 to 5 year time frame, starting FY17. This would allow communities to be able to adjust with smooth transitions due to changes in funding base, both upwards and downwards; AND FUNDING WOULD BE MORE PREDICATABLE, AND SIGNIFICANTLY MORE EQUITABLE THAN WHAT HAS BEEN EXPERIENCED FROM APRIL 2014 TO THE PRESENT, Ie the past two and a half years.

I would also note, that based on my calculations, it would take $22m to bring the below state average CMHSPs, in this new model, up to the state average.

I would urge you to apply what pressure you can to have the state move ahead with the model developed by the workgroup, and to begin to implement the model with FY17 authorizations to the 46 CMHSPs.

Thank you.

Judith Taylor